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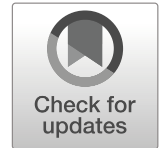

RESEARCH ARTICLE

The Training Experiences of Behavior Analysts: Compassionate Care and Therapeutic Relationships with Caregivers

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Abstract
Successfully working with families of children with autism requires technical behavior-analytic skills and critical interpersonal relationship-building skills. Taylor, LeBlanc, and Nosik (2018) suggested that many Board Certified Behavior Analysts might have been trained in graduate programs that focus primarily on conceptual and technical skills with little coverage of skills related to building therapeutic relationships. The current paper provides the results of an online survey of the precredential and postcredential training experiences of behavior analysts. The majority of behavior analysts surveyed indicated that they received no explicit didactic training or reading assignments on relationship-building skills in their graduate coursework in behavior analysis. Approximately half indicated that their practical experience supervisor provided guidance and mentoring on these skills. The majority of behavior analysts indicated that it is very important or extremely important that professional training programs develop formal training in this area.

Keywords Autism · Compassion · Empathy · Professional training · Therapeutic relationship

The last decade has seen tremendous growth in the number of children with autism receiving applied behavior analysis (ABA) services, in the number of Board Certified Behavior Analysts (BCBAs) serving them, and in the number of institutions of higher education providing professional training for those aspiring BCBAs (Autism Speaks, 2017; Behavior Analyst Certification Board [BACB], n.d.; Carr & Nosik, 2016). Taylor, LeBlanc, and Nosik (2018) made the case that therapeutic relationship skills (e.g., empathy, compassion, rapport building) are a critical part of the repertoire of a successful BCBA because of the potential positive impact on family satisfaction, adherence to treatment, and improved clinical outcomes. Taylor et al. further hypothesized that failure to engage in critical relationship skills may negatively impact treatment, including parental nonsupport of treatment recommendations, requests for reassignment to a different clinician, or termination of behavior-analytic services altogether. This hypothesis is consistent with reports from other health care professions (Bonvicini et al., 2009; Epstein, Campbell, Cohen-Cole, Whinney, & Smilkstein, 1993; Koya, Anderson, & Sice, 2017; Leach, 2005). Several studies in the health care industry have reported a relationship between care described as "empathetic" or "compassionate" and improved treatment outcomes, reduced risk of professional litigation, improved patient adherence to medical protocols, and greater likelihood that patients will share qualitative assessment information (Bonvicini et al., 2009; Epstein et al., 1993; Koya et al., 2017; Leach, 2005). The establishment of these therapeutic relationship skills can also directly influence practitioners themselves. For example, Koya et al. (2017) suggested that nurses who establish therapeutic alliances with their patients may have less stress and improved work performance, including making better strategic decisions..

Despite the perceived relevance of relationship-building skills of clinicians in other health care industries, the potential benefits of these skills in behavior-analytic treatment have not garnered the same attention in research or practice. Nonetheless, the importance of therapeutic relationship skills is evident in several places in the *Professional and Ethical Compliance Code for Behavior Analysts* (the Code; BACB, 2016) and the BACB Task List (Task List; BACB, 2014). For example, the Task List includes items related to collaboration

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with other professionals (H-9) and the recommendation of intervention goals and strategies based on such factors as client preferences and social validity (H-4, i.e., treatment acceptability; Wolf, 1978). The Code also speaks to the importance of the relationship between the BCBA and the family in sections 1.05 and 3.04, about clear, effective communication in language that is fully understandable to service recipients, and sections 2.0 and 4.0, about the ongoing collaborative process with the client, family, and other important people in the environment "throughout the duration of the client-practitioner relationship" (p. 12).

In order to determine how behavior analysts fare with respect to relationship-building skills with parents, Taylor et al. (2018) conducted a survey of parents of children with autism regarding their impressions of behavior analysts' relationship skills. The survey items sampled relationship variables grouped into three domains: listening and collaboration, empathy and compassion, and "negative" behaviors of the behavior analysts that could contribute to problems in the therapeutic relationship. The results of that survey indicated that behavior analysts have some skills in each area and at least some deficits in a number of core relationship skills. For example, areas needing improvement included compromising, inquiring about satisfaction, acknowledging mistakes, being patient and reassuring, and not being too authoritarian.

Taylor et al. (2018) suggested several variables that may contribute to these deficits. First, academic training programs in behavior analysis may not incorporate training in these skills as part of their professional training curriculum and may not include relevant assigned readings in this area (Pastrana et al., 2016). Second, graduate programs may overemphasize technical training and verbal accuracy, leading to behavior analysts' overuse of technical language, which could be perceived by parents as authoritative rather than collaborative (Critchfield et al., 2017). Additionally, graduate programs or practical experience sites may fail to train clinicians in the potential emotional responses (e.g., anger, sadness, guilt, fear) that a parent of a child with autism may experience (Bozosi, 2016; Fiske, 2017; Lutz, Patterson, & Klein, 2012; Post et al., 2013), resulting in clinicians ill prepared to respond to parental stress and emotion (Hayes & Watson, 2013).

The requirements for behavior-analytic practice credentials include both academic coursework and supervised practical experiences, either of which could include training in these critical skills. Although Pastrana et al.'s (2016) review of frequently assigned articles in graduate training programs in behavior analysis did not identify any articles related to the importance or teaching of therapeutic relationship skills, it is possible that the topic may be covered in some practical experiences or in academic programs via other means than assigned readings. The current study was designed to examine the suggestion by Taylor et al. (2018) that graduate training programs in behavior analysis may not be teaching skills related to compassionate care and therapeutic relationships. The purpose of the current study was to identify the impressions of certified professionals (i.e., BCBAs, Board Certified Assistant Behavior Analysts [BCaBAs], and doctoral-level BCBAs [BCBA-Ds]) regarding their academic and applied training experiences in compassionate care and therapeutic relationship skills. We surveyed certified behavior analysts about their training experiences and postgraduate professional development experiences in therapeutic relationship skills and compassionate care.

Method

Participants

This study focused on board-certified individuals (i.e., BCaBAs, BCBAs, BCBA-Ds). We recruited participants through the BACB e-mail service, as well as through some state-level professional organizations (e.g., the Colorado Association for Behavior Analysis) and various social media sites (i.e., e-mail discussion lists, Facebook posts). The number of individuals who received the invitation to participate is unknown, so a corresponding response rate was not calculated. All responses were included in the analysis, which means some respondents could skip a question and the questions that were answered for that respondent's survey were included in the analysis. In other words, respondents were not required to answer every question to participate in the survey. A total of 225 surveys were collected and analyzed.

Instrumentation

The survey, approved by Alpine Learning Group's Institutional Review Board, was developed within SurveyMonkey, a survey software tool with the ability to distribute and anonymously collect and analyze responses via the Internet. The instrument consisted of four sections: demographics, university graduate training and practical experience, postcertification professional development, and observations about practice and the value of training in compassionate care and therapeutic relationships. The second and third sections posed dichotomous questions (i.e., yes/no format) designed to assess prior training and professional development experiences. The questions in the fourth section could be answered with 5-anchor (e.g., *strongly agree* to *strongly disagree*) responses. Follow-up questions and open-response options were contingent on the participant's response to the initial question (e.g., the "Yes, I hold a license or certificate in another field" response opened an option to provide additional information about that license or experience).

Procedure

Invitation e-mails were sent through the BACB e-mail list service with the web address link for the survey. The survey was also distributed by the authors on various social media sites (e.g., state or local ABA chapters) and personal Facebook postings. Recruitment and data collection were conducted from September 10, 2018, through November 4, 2018. Survey participants were provided with the option to include their identifying information (e.g., e-mail) to be eligible to be one of two winners of a $50.00 gift card for completing the survey; 159 respondents provided identifying information to be eligible to win a gift card. Following survey closing date of November 4, 2018, two gift card winners were randomly identified and contacted to inform them of being a gift card winner.

The survey was designed to determine the training experiences of behavior analysts in the area of compassionate care and therapeutic relationship-building skills, their impressions of the importance of these skills, the need for training of colleagues and themselves in this area, and how likely they would be interested in participating in training in this area. Questions were created by the authors based on informal discussion and designed to capture a variety of ways that certificants could have encountered training. For example, the question “How important is it that professional training programs in ABA develop formal training in the area of compassion, empathy, and building therapeutic relationships with families?” was followed by a 5-option ranking from *extremely important* to *not at all important*. Some questions were also provided with a comment box so respondents could provide additional information. For example, the question “As a supervisor of behavior analysts in training, are you ever concerned that those whom you are supervising lack skills in the area of compassion, empathy, and building therapeutic relationships with families?” provided a comment box so respondents could comment on their experience with supervisees.

Table 1 Participant primary credentials, work settings, and roles

Questions and Response Options	% Endorsed
How long have you held your current certification level?	
Less than 1 year	9
1–2 years	11
3–5 years	26
6–10 years	30
More than 10 years	23
Do you hold another credential besides BCBA? If so, what field?	
No second credential	6
Education	22
Psychology	11
Counseling	2
Social work	2
What is your primary work setting?	
Center or clinic	30
Home	23
Public school	14
Private school	12
Community	11
College or university	10
Hospital	1
What is your primary employment role?	
Supervisor	49
Practitioner (direct service)	22
Administrator	17
Educator	12

Results

Respondent Demographics

Two hundred twenty-five respondents provided consent and completed the survey. Four respondents indicated they were not certified. These data were excluded from the survey results. Thus, 221 surveys were included in the analysis. Some respondents did not answer every question; therefore, the mean score was based on the number of respondents for that particular question. In general, most respondents completed the demographic responses, and a subset provided answers to the remainder of the questions (i.e., all remaining questions about training experience; range = 200 – 202 respondents). Table 1 summarizes some of the more salient demographics; others are reviewed here. The sample was primarily female (*n* = 191, 85%), between the ages of 31 and 50 (*n* = 107, 47%), who held a BCBA credential (*n* = 169, 76%) followed by a BCBA-D credential (*n* = 40, 18%). The majority had been certified for 3 or more years. The distribution of time that these professionals had held their credentials is presented in Table 1 with a range of less than 1 year to more than 10 years. Thirty-two percent of these individuals held an additional credential, and education was the most commonly reported additional credential (*n* = 44), followed by psychology (*n* = 22).

Most respondents provided services to individuals with autism (*n* = 169, 78%), followed by intellectual disabilities (*n* = 22, 10%). The majority of respondents primarily provided services to children aged 13 and under (*n* = 172, 77%). The majority (80%) indicated that they interact directly with families either sometimes (26%) or frequently (55%). An even higher percentage indicated that they are mentoring others who interact directly with families either sometimes (27%) or frequently (65%). The distributions of responses for primary work setting and primary work role were relatively evenly distributed across response options and are also presented in Table 1.

Training in Therapeutic Relationship Skills

Table 2 provides the results for all the questions on the survey on training experiences. A relatively small percentage of responding behavior analysts had lectures or assigned readings in their undergraduate or graduate coursework in behavior analysis on these topics (28%). Most (72%) reported that they had not had any in-class lectures that covered the topics, and the majority of respondents (78%) reported no assigned readings. Most (82%) also reported not having any formal training in their practicum or supervised experience. However, half of the respondents indicated that these skills were addressed in mentored practical experience, suggesting that our field relies on individual supervision and the skill sets of the individual supervisor to establish these repertoires for the trainee. For example, one respondent commented, "Clinical issues concerning these topics were discussed in weekly supervision."

Forty-five percent of respondents indicated that they encountered some type of training in this area outside of their training in behavior analysis (e.g., degrees in psychology, counseling, social work), suggesting that these skills are being addressed more often in other graduate training programs. An analysis of data across these other disciplines revealed that formal training in these skills occurred for 100% of respondents in preparation for their degree in social work, 77% for training in psychology, 42% for training in education, and 33% for training in counseling.

Of the total respondents, 59% indicated that they pursued professional development activities on their own on these topics. Thus, survey respondents indicated they have primarily experienced training in this area from academic instruction in another degree, in their practicum setting, from their employers, from the published literature, or through ongoing professional development experiences such as conferences. The majority of respondents (58%) who are leaders in their organizations have provided this type of training for their employees.

Table 3 provides the results for all the questions about the importance of training in this area and the perceived need for this training. The majority of respondents (82%) reported that they either sometimes or often feel unprepared or not trained to respond to the emotional responses of a family member. For example, one respondent reported, "I have felt unprepared when interacting with hostile families, or families who indicate dissatisfaction with services, or who respond with anger towards other situations in life (e.g., marital problems, sibling issues)."

An even higher percentage of respondents (94%) felt like their colleagues either sometimes or often struggle with these skills. One respondent, for example, stated, "Some BCBAs are all business and lack compassion; they expect families to comply no matter what." Most respondents (91%) felt like skills in this area are very important or extremely important, and that professional training programs (e.g., master's programs in behavior analysis that are producing BCBAs) should be teaching these skills to practitioners (83%). There was a slight difference between male versus female impression of the importance of these skills: 59% of female respondents reported these skills to be extremely important, whereas 48% of male respondents did. Similarly, female respondents viewed graduate training of these skills as extremely important more often than male respondents did (i.e., 50% female, 48% male). A high percentage of total respondents indicated that they agreed or strongly agreed with statements that ongoing professional development in these skills is important for themselves, their colleagues, and new behavior analysts in training (81%, 93%, and 94%, respectively).

Table 2 Training experiences in the topics of compassion, empathy, and therapeutic relationships with families

Question	% Yes
During your university training (e.g., undergraduate, graduate) in behavior analysis, did you have:	
Lectures?	28
Readings?	24
During your supervised practical experience (e.g., practicum, fieldwork) in preparation for BACB certification, did you have:	
Didactic training?	18
Mentored practical experience?	50
Did you encounter training that covered the topics for another degree, certification, license, or discipline (e.g., psychology, social work, education), outside of your training as a behavior analyst?	45
Separate from your graduate training or preparation for certification, have you had didactic training (e.g., lecture, workshop) that covered the topics that was provided by your employer?	40
Separate from your graduate training or preparation for certification, have you independently pursued didactic training (e.g., lecture, workshop) that covered the topics that was provided by someone other than your employer (e.g., conference workshop)?	44
Separate from your graduate training or preparation for certification, have you independently pursued professional development activities (e.g., reading articles or books) besides a workshop that covered the topics?	59
Separate from your graduate training or preparation for certification, have you independently pursued mentored or supervised experience focused on the topics?	23
If you are in a supervisory or leadership role in your organization, have you developed a training or mentored or trained your employees on the topics?	58

Discussion

The results of this survey seem to support Taylor et al.'s (2018) premise that graduate training programs for behavior

Table 3 Importance of the topics of compassion, empathy, and skills for developing therapeutic relationships with families

Question and Response Options	% Endorsed
As a practicing behavior analyst, have you ever been in a professional situation where you felt unprepared or not trained to respond to the emotional responses (e.g., anger, sadness) of a family member (e.g., parent) of a client?	
Yes, often	9
Sometimes	74
Never	18
As a practicing behavior analyst, are you ever concerned that your colleagues lack skills in the area of compassion, empathy, and building therapeutic relationships with families?	
Yes, often	47
Sometimes	48
Never	5
As a supervisor of behavior analysts in training, are you ever concerned that those whom you are supervising lack skills in the area of compassion, empathy, and building therapeutic relationships with families?	
Yes, often	19
Sometimes	52
Never	7
I don't supervise.	22
As a practicing behavior analyst, how important do you view skills in the area of compassion, empathy, and developing therapeutic relationships with caregivers?	
Extremely	58
Very	33
Somewhat	9
Not very	0
Not at all	1
How important is it that professional training programs in ABA develop formal training in the area of compassion, empathy, and building therapeutic relationships with families?	
Extremely	50
Very	33
Somewhat	15
Not very	2
Not at all	1
How likely would you be to seek out training and/or mentoring in the area of compassion, empathy, and building and sustaining therapeutic relationships with families?	
Very likely	34
Likely	41
Neither likely nor unlikely	14
Unlikely	8
Very unlikely	2
Do you agree that you would professionally benefit from training and/or mentoring in the area of compassion, empathy, and building and sustaining therapeutic relationships with families?	
Strongly agree	42
Agree	39
Neither/neutral	13
Disagree	4
Strongly disagree	1
Do you agree that your colleagues would benefit from training and/or mentoring in the area of compassion, empathy, and building and sustaining therapeutic relationships with families?	
Strongly agree	50
Agree	44
Neither/neutral	6
Disagree	below 1
Strongly disagree	below 1
Do agree that the behavior analysts whom you are supervising would benefit from training and/or mentoring in the area of compassion, empathy, and building and sustaining therapeutic relationships with families?	
Strongly agree	45
Agree	33
Neither/neutral	3
Disagree	1
Strongly disagree	below 1
I don't supervise.	18

analysts are not teaching skills in the area of compassion, empathy, and building therapeutic relationships with caregivers. Despite most behavior analysts viewing this as a very or extremely important skill, respondents indicated that they received little or no training in this area at their training program. Additionally, the survey results revealed that the responsibility of teaching these skills seems to fall to supervisors and employers in applied settings, who themselves may not have had explicit training in these skills. The results may support this hypothesis, as a large percentage of respondents indicated that their primary role was supervisor (i.e., 49%), yet 56% indicated they had only 3–10 years of experience. It is likely, given the variable and limited number of years of experience, that these supervisors providing training may themselves have had little training in these skills. It is also unclear if the content of this reported training in applied settings was behavior analytic and how uniform it may have been across settings and supervisors.

As suggested by Taylor et al., and as our survey results seem to support, behavior analysis should move toward providing comprehensive training in core competencies related to compassionate and empathic care and the skills necessary to build therapeutic relationships with caregivers. If, as other health care industries are reporting, positive, empathic relationships between clinicians and caregivers could potentially impact outcomes (e.g., Karver, Handelsman, Fields, & Bickman, 2006; Lown, 2016; Reiss et al., 2016; Riess, 2015; Sinclair et al., 2016), then behavior analyst training programs should also be incorporating training in these

essential skills. Although the impact of these skills on our clinical outcomes remains an empirical question, developing training programs in these skills is one step toward answering this question.

It may be challenging to identify how to fit this content into already-existing academic curricula in behavior analysis. However, coverage on therapeutic relationships could be added into an existing practicum class (i.e., a weekly lecture that accompanies the practicum or fieldwork experience) and could be reviewed in ethics courses or elective courses on special topics (e.g., autism and developmental disabilities) for students who intend to practice behavior analysis with families who have an individual with special needs. Additionally, graduate programs that could not find a way to add the content given their current resources might offer suggested readings in this area, require students to enroll in a workshop offered at a conference or online training experience, or rely on an existing course in another department in the university (e.g., clinical psychology, counseling psychology). Further, the Fifth Edition Task List for BCBAs, required by the year 2022, requires 30 hr of graduate coursework in personnel supervision and management (BACB, n.d.). Thus, training content in the areas of compassion, empathy, and building therapeutic relationships with caregivers could be included in this required coursework. It could be the case that this content area and training in these skills could occur as part of the supervisory process. This would require that supervisors receive training in these skills so that they can identify and shape these repertoires in those whom they are supervising.

Once training programs are developed, empirical evaluation of the training and the impact of these skills on clinical care could proceed. Training studies focused on teaching these skills to clinicians in other health care fields may serve as an example for behavior analysis (see the review by Kelm, Womer, Walter, & Feudtner, 2014). For example, in a notable study by Riess, Kelley, Baily, Dunn, and Phillips (2012), physicians were taught to improve awareness of their patients' emotional verbal and nonverbal behavior and respond to these communications with empathic understanding. Additionally, the participating physicians were taught to use those skills in challenging patient interactions. Residents and fellows were randomly assigned to receive either standard postgraduate medical education or education augmented with three 60-min empathy training modules. Dependent measures included blind patient ratings pretraining and additional ratings on the Consultation and Relational Empathy (CARE) measure 1 to 2 months posttraining. Results indicated that the group who received supplemental empathy training showed greater changes in patient-rated CARE scores than the control group did. Physicians who received empathy training also reported more awareness of and a greater ability to handle their own emotional reactions when working with patients. A similar training could be designed and empirically evaluated for behavior analysts.

Although the results seem to support Taylor et al.'s (2018) hypothesis that graduate training programs do not provide training in these skills, the results should be interpreted cautiously, as the sample size is small compared to the total number of certified professionals (at the time the survey was distributed, there were over 35,000 certified individuals; BACB, n.d.). Additionally, this survey relies on the impressions of behavior analysts who have already gone through academic training programs. It could be the case that those programs now include training in these skills. Also, we did not analyze actual course content, nor did we survey professors of graduate programs to determine if these skills are addressed or incorporated in their course sequences. Future analyses might include surveys to instructors in behavior analysis programs to determine if their academic programs provide training in these skills.

The current survey sought to determine behavior analysts' impressions of and training experiences in compassionate care and therapeutic relationship skills. The results indicated that behavior analysts value these skills and view them as essential but received little training in these skills. Although empirical research is needed to evaluate the training of these skills, Taylor et al. (2018) proposed a curriculum outlining potential relationship skills that could be targeted as part of a training program. Once training programs are empirically validated, applied research can follow to determine the impact of these skills on the social validity of our interventions and our clinical outcomes.

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflicts of interest.

Ethical Approval All procedures performed were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent The participants in the survey were not identifiable and provided consent by completing the survey.

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